Baptist Union of Scotland: A Connected Scotland Response
April 2018

Submitted to A Connected Scotland: Tackling social isolation and loneliness and building stronger social connections
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Key questions for everyone

Q1. What needs to change in your community to reduce social isolation and loneliness and increase the range and quality of social connections?

We need leadership from the key stakeholders in our communities demonstrated by; listening to those who find themselves isolated, engagement with all 3rd sector bodies, imaginative opening up of public spaces and buildings, a greater integration of services, greater empowerment to local bodies, as they are best placed to understand the needs of their communities.

Q2. Who is key at local level in driving this change, and what do you want to see them doing more (or less) of?

Key change drivers are: Local charities and community groups e.g. tenant & resident groups, community councils, churches. Other key stakeholders have a part to play e.g. schools, social workers, healthcare workers, public services but often they do not live in the community and are unaware of the needs of the community outside office hours.

Q3. What does Government need to do nationally to better empower communities and create the conditions to allow social connections to flourish?

The Government should work towards a greater integration of local services, especially among the key stakeholders and reduce bureaucracy to make it easier for different frontline agencies and community groups to access resources and funds directly. The Government could discourage the depopulation of town centres in favour of out-of-town shopping malls so that people are more aware of who has dropped off the radar, not visible in local shops etc.

Detailed questions:

Q4. Do you agree or disagree with our definitions of (i) social isolation and (ii) loneliness?

We disagree with this definition. Your definition is a definition of social capital. Social isolation equals the reduction in social capital. With regards to l, we would replace “ideal” with “desired”. Desired levels of social relationship can only be determined by the individual and therefore no overall definition of “ideal” would always be appropriate.

Q5. Do you agree with the evidence sources we are drawing from? Are there other evidence sources you think we should be using?

The relationship between loneliness and mortality is of the same magnitude as that of other well established risk factors such as smoking, obesity and lack of exercise. Loneliness is

associated with a 30% increase in Cardiovascular disease.[1] Feelings of loneliness and reduced social networks are more prevalent among mental health service users than in the general population.[2] There is also a negative association between spiritual wellbeing and loneliness.[3] It was also well described by Pink et al, that GPs perform a surrogate priestly role in presentations such as bereavement, loneliness and social isolated. [4] The current chair of the RCGP used her inaugural conference speech to call for more time for lonely patients and additional members of the healthcare team to care for the lonely or isolated13. Primary Care Chaplaincy is being utilised by those with reduced social capital and loss of wellbeing to respond to these challenges.[5] It was surprising that there was no reference to GPs who must be one of the front-line professionals encountering loneliness.

Q6. Are there examples of best practice outside Scotland (either elsewhere in the UK or overseas) focused on tackling social isolation and loneliness that you think we should be looking at?

Nuka is a noteworthy project in Alaska amongst Native American Indians who have created an extended network or community around patient's health care workers. Each member of the health care team from the cleaner up is responsible for a number of patients and befriends, monitors, supports and offers continuity of care – very much akin to pastoral care groups.

Q7. Are you aware of any good practice in a local community to build social connections that you want to tell us about?

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[1] Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. PLoS Med 2010;7(7):e1000316. See also: Holt-Lunstad J, Smith TB. Loneliness and social isolation as risk factors for CVD: implications for evidence-based patient care and scientific inquiry. Heart 2016;102(13):987-9. doi: 10.1136/heartjnl-2015-309242; Valtorta NK, Kanaan M, Gilbody S, et al. Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review andmeta-analysis of longitudinal observational studies. Heart 2016;102(13):1009-16. doi: 10.1136/heartjnl-2015-308790; Wang J, Lloyd-Evans B, Giacco D, et al. Social isolation in mental health: a conceptual and methodological review. Soc Psychiatry Psychiatr Epidemiol 2017;52(12):1451-61. doi: 10.1007/s00127-017-1446-1

[2] Clinton M, Lunney P, Edwards H, et al. Perceived social support and community adaptation in schizophrenia. J Adv Nurs 1998;27(5):955-65; Borge L, Martinsen EW, Ruud T, et al. Quality of life, loneliness, and social contact among long-term psychiatric patients. Psychiatr Serv 1999;50(1):81-4. doi: 10.1176/ps.50.1.81; Lauder W, Sharkey S, Mummery K. A community survey of loneliness. J Adv Nurs 2004;46(1):88-94. doi: 10.1111/j.1365-2648.2003.02968.x

[3] Miller JF. Assessment of loneliness and spiritual well-being in chronically ill and healthy adults. J Prof Nurs 1985;1(2):79-85.

[4] PINK, J., JACOBSON, L. & PRITCHARD, M. 2007. The 21st century GP: physician and priest? Br J Gen Pract, 57, 840-2

[5] Macdonald G. Primary care chaplaincy: a valid talking therapy? The British journal of general practice : the journal of the Royal College of General Practitioners 2017;67(655):77. doi: 10.3399/bjgp17X689221

Many churches all over Scotland are engaged in programs that help to tackle social isolation e.g. after school clubs, toddlers groups, youth clubs and events for the elderly. Some specific examples:

- Kirkintilloch Baptist Church - New Creations Group (local addiction recovery group) – Eden project in Hillhead area, Food bank, Job Club. In all these areas the Church is working as a referral point from primary care.
- Carluke Baptist Church – working with people isolated as a result of alcohol addiction including daily visits to deliver medication, befriending and spiritual care. Hosting events for other stakeholders, e.g. an support group for parents of children on the autistic spectrum where parents can also bring their children (it is the only group of its kind in their area).
- Sheddocksly Baptist Church, Aberdeen and East Mains Baptist, East Kilbride – both these churches are reducing isolation for the elderly and disabled persons through whole person health care delivered through the Parish Nursing initiative. All the staff are registered nurses employed by these churches to provide support alongside NHS care.
- Motherwell Baptist Church, provides a low cost café as a place of welcome and access point to other support networks. Support workers are then able to help them relate better to local authority and government bodies such as courts, benefit agencies, social workers. This type of work is replicated across the Baptist network in Scotland
- A number of churches are involved the Men's Sheds Association, they do a significant job in connecting men and alleviating loneliness.

Q8. How can we all work together challenge stigma around social isolation and loneliness, and raise awareness of it as an issue? Are there examples of people doing this well that you're aware of?

Education / advertising of the issues around social isolation and the available help in key locations, schools, GP surgeries etc. One solution might be to create communities around primary care for example a walking group might provide social interaction and the necessary health benefits could be part of a coordinated response.

Q9. Using the Carnegie UK Trust's report as a starting point, what more should we be doing to promote kindness as a route to reducing social isolation and loneliness?

I don't know how this could be done, but I think the press have a role to play in shaping social attitudes towards vulnerable people. The concept of "kindness" resonates with our experience. Perhaps there needs to be more focus on mentoring of such values in front line services such as schools and surgeries. It seems that such values are more easily grasped and more likely to be transmitted by observation rather than "telling". This may require the leaders of such organisations to model values such as kindness and compassion. It should also be noted that kindness is less effective than love, the idea of sacrificial love, a key concept of Christianity need somehow to be recovered in society.

Q10. How can we ensure that those who experience both poverty and social isolation receive the right support?

More integration and connectedness of services and stakeholder groups, for example, new mothers (especially single mothers or those without family support) could be directed to toddlers groups as part of their primary care. In our experience most women attending such groups form lasting friendships and isolation is reduced. For example we would like to see the childcare provision, provided primarily by churches, supported at a national level both through encouragement and financial resources.

Q12 How can health services play their part in better reducing social isolation and loneliness?

Health services could function as central hub for communities as they are already a natural point of contact for many in the community. Integrated care provided perhaps by links workers, signposting those experiencing isolation to relevant services. Local volunteering groups from within the existing community of primary care could be established to serve the needs of their own surgery's population. Loneliness functions as one further "modern malady" as described by Phil Hanlon.[6] The other modern maladies we see are loss of wellbeing, obesity, addictive behaviours and depression / anxiety. Each of these are common presentations to primary care. Isolation and loneliness deprive people of the opportunity to talk about their problems and so they often attend the GP. One response to this has been primary care chaplaincy.[7]

Q13. How can we ensure that the social care sector contributes to tackling social isolation and loneliness?

Ultimately this requires a shift of money from secondary care to Health and Social Care partnerships to invest in initiative such as befriending, bespoke person centred day care, locally funded groups (such as walking groups, chair based creative groups for those with long term conditions)

Q14. What more can we do to encourage people to get involved in local groups that promote physical activity?

GP Surgeries in Glasgow have been provided a link worker to signpost patients to relevant groups. It would be helpful if this could be rolled out to all practices. One of the key obstacles for vulnerable patients engaging locally is lack of confidence. Local "champions" would be helpful to meet such patients and take them to their chosen event, whether that be sports,

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[6] Hanlon P, Carlisle S, Hannah M, et al. Making the case for a 'fifth wave' in public health. Public Health 2011;125(1):30-6. doi: 10.1016/j.puhe.2010.09.004

[7] Macdonald G. Primary care chaplaincy: a valid talking therapy? The British journal of general practice: the journal of the Royal College of General Practitioners 2017;67(655):77. doi: 10.3399/bjgp17X689221; Macdonald G. The efficacy of primary care chaplaincy compared with antidepressants: a retrospective study, comparing chaplaincy with antidepressants. Prim Health Care Res Dev 2017:1-12. doi: 10.1017/S1463423617000159

fitness or life skills classes. The cost of access to organised physical activity is likely to be prohibitive for some people. Can the Scottish Government look at reducing cost of access for vulnerable people enabling cheaper access to local groups promoting physical activity?

Q15. How can we better equip people with the skills to establish and nurture strong and positive social connections?

Work with local groups to educate and inform them about the causes and impact of social isolation in communities and then empower them to work with the Government to tackle the problem.

Q16. How can we better ensure that our services that support children and young people are better able to identify where someone may be socially isolated, and capable of offering the right support?

Part of the answer lies in training those who work with children and young people to identify loneliness and isolation and enable them to provide strategies to combat ACEs.

Q17. How can the third sector and social enterprise play a stronger role in helping to tackle social isolation and loneliness in communities?

Churches have a major role to play in tackling social isolation as they are already embedded into virtually every community in Scotland and most will already be engaged in programmes to help tackle these kinds of issues. Greater cooperation between churches and local authorities, NHS, Social Work, Police etc. is likely to provide a joined-up approach to tackling social isolation and exclusion regardless of the causes at a local level.

Q18. What more can the Scottish Government do to promote volunteering and help remove barriers to volunteering, particular for those who may be isolated?

Q23. How best can we ensure that people have both access to digital technology and the ability to use it?

Fundamentally this requires the provision of technology is public services and spaces - schools, libraries, GP surgeries etc. It also requires the provision of community/public broadband and training courses for all ages that are accessible both financially and physically.